



COUNTY OF LOS ANGELES OFFICE OF CHILD PROTECTION

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September 2, 2016

To: Supervisor Hilda L. Solis, Chair
Supervisor Mark Ridley-Thomas
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From: Judge Michael Nash (Ret.) 
Executive Director

REPORT ON FEASIBILITY OF TRANSFERRING THE DEPARTMENT OF CHILDREN AND FAMILY SERVICES (DCFS) PUBLIC HEALTH NURSES (PHN) TO THE DEPARTMENT OF PUBLIC HEALTH (DPH)

On August 2, 2016, the Board directed the Office of Child Protection (OCP), in collaboration with the Chief Executive Office (CEO), DCFS, and DPH and applicable unions, to report back on the feasibility, benefits and detriments, if any, and fiscal viability of the OCP's recommendation to transfer the DCFS PHNs to DPH. As a friendly amendment, the CEO was instructed to look at the average caseload data in all of the offices, including DCFS, and include in the report back to the Board ways to assist.

In addition, DCFS, DPH, and the OCP were instructed to provide recommendations to the Board on how to effectively maximize the use of PHNs; and instructed the Director of DCFS to report back with further research and analysis including soliciting feedback from children's social workers (CSWs) and PHNs on the effectiveness of the joint visitation initiative, the pilot effort and the overall role of each contributing component, as well as to consider obtaining feedback from the families that have been or would be served by the Pilot program.

The OCP worked in collaboration with each department noted in the motion and is providing a consolidated response to the motion.

FEASIBILITY

In order to evaluate the feasibility of moving the DCFS PHNs to DPH, the OCP considered the interests of the involved departments, the PHNs, and SEIU 721; the staffing items that would be affected; whether the staff would need to be physically relocated; and, if any additional resources would be needed in order to successfully consolidate the two programs under one department.

There is support from both DCFS and DPH to consolidate the DCFS PHNs under DPH. It is anticipated that the consolidation of the PHNs under DPH would allow for the provision of better service to the children and families through increased communication, standardized processes, common training, medical structure, and coordinated trauma-informed care. Also, it is believed that the consolidation of nurses into one department would help to eliminate the confusion for CSWs as to which PHN (either DCFS or DPH) would be able to assist them.

The PHNs and SEIU 721 are also supportive of the DCFS PHNs moving to DPH (see Attachment 1). However, they have also voiced some concerns, including:

- Inclusion at the table for any discussion regarding them;
- Understanding that consolidation would not resolve the current shortage of PHNs or caseload ratios;
- Consideration of the increasing workload on the PHNs as a result of hiring more needed CSWs, as well as new legal mandates on monitoring psychotropic medication;
- Training is needed to improve communication across functions and departments; and
- Consideration of how the existing DPH staffing structures would be able to support doubling the size of the PHN staff.

Staffing Items Affected

Table 1 reflects the staffing items that support the DCFS PHN program and includes the PHNs, their clinical supervisors and manager, as well as their direct administrative support. These ordinance items are being considered for inclusion in the transfer of the DCFS PHNs to DPH, if the transition of the PHN program is approved.

Table 1: Current DCFS Staffing for the PHN Program				
Items		DCFS		
		Ordinance	Budgeted	Filled*
5230A	Public Health Nurse	92	75	76
5236A	Public Health Nursing Supervisor	13	10	13
5237A	Program Specialist, Pub Health Nursing	1	1	1
5286A	Nurse Manager	1	1	1
2096A	Secretary III	1	1	1
2214A	Intermediate Typist-Clerk	8	8	8
Total Items		116	96	100

Please note, the 20 items (17 PHNs and 3 PHN Supervisors)

*Filled positions as of 8/22/2016

approved for the CSW-PHN Joint Initiative are ordinance only items, which is why the ordinance items exceed the budgeted items by 20 items. DCFS has indicated they would continue to fund these items through the transition, if approved; however, additional ongoing funding may need to be considered as part of the overall program funding and staffing plan for the long-term.

DPH and DCFS agreed that DCFS will need to maintain a liaison within their office to

work with the PHNs. DCFS will retain one Intermediate Typist-Clerk to assist the liaison (item not included in Table 1).

As mentioned previously, the PHNs and SEIU 721 support consolidating the DCFS PHN program into DPH. The PHNs from both departments are represented by SEIU 721, so the PHN rights, salaries, cost of living increases, as well as their fringe benefits are set by their respective negotiated memorandum of understandings (MOUs), and as such will not be impacted by any transfer from one department to another. The Intermediate Typist-Clerks are also represented by SEIU 721, and we have begun including their representative in these discussions.

In addition, the DCFS items reflected in Table 1 are classifications that PHN currently utilizes and have ordinated within DPH. Therefore, CEO-Classification does not see any issues with the transfer of these items to DPH.

Space/Location of Staff

If the DCFS PHN program were to be consolidated into DPH, it is anticipated that the majority of the staff would continue to be located in the DCFS regional offices. However, the Nurse Manager and the Program Specialist positions are currently located at DCFS Headquarters and will most likely need to be relocated to DPH's-Children's Medical Services (CMS) headquarters.

Anticipated Resources Needed

DPH anticipates that an Assistant Nursing Director would be needed to structurally support the larger program, and may request this item, if the consolidation is approved. The anticipated salary of an Assistant Nursing Director is between \$9,874 and \$14,345 per month.

DPH also anticipates there would be a need for other staff assistance such as IT support for their staff located in the regional offices or fiscal assistance to resolve any potential billing issues. DCFS and DPH will work together to ensure the resolution of these issues are detailed in their interdepartmental MOU.

POTENTIAL BENEFITS TO CONSOLIDATION

There are several anticipated benefits to consolidating the DCFS PHNs under DPH that have been identified:

- Improved ongoing medical care coordination for the children through an enhanced warm handoff by the "front-end" PHN to the "back-end" PHN, as well as through the Supervising PHNs working with both the "front-" and "back-end PHNs." This enhanced handoff would be developed and formalized, and help to eliminate the gaps in service between the investigation phase and the opening of a case.

- Access to extensive training that regularly occurs for the PHNs at DPH to help maintain a consistent knowledge base. These trainings are eligible for continuing education units and may include: nursing administration training, public health trainings, targeted trainings, etc.
- Improved support through DPH's multi-level medical reporting structure that provides guidance and consultation to PHNs. In addition to the de facto medical director overseeing the foster care PHN program, PHNs are encouraged to consult with the CMS court pediatrician and CMS medical director, if needed.
- Increased opportunities for job growth, since DPH has multiple, varied nursing programs under its purview. In addition, there is a possible career ladder for the PHNs at DPH, both within and outside their program, as DPH operates several nurse run programs.
- Improved clarification of roles and responsibilities for the PHNs and the CSWs, as well as alignment of data collection categories for the PHNs would be documented and included in the interdepartmental MOU.
- Operational efficiencies may be achieved over time as the programs become more integrated.
- Improved communication between the departments would occur around the children and families being served by DCFS and DPH.

POTENTIAL DETRIMENTS TO CONSIDER

Two potential detriments to consolidation were identified:

- There is a concern that the DCFS PHNs may become more public health focused under DPH and lose their child welfare safety lens.
- There is a concern that the DPH funding stream may be subject to future State funding cuts, similar to what has occurred previously, which could impact the staffing positions.

FISCAL VIABILITY

The funding entities, California Department of Social Services (CDSS) and Department of Health Care Services, were made aware of this motion to investigate the feasibility of consolidating the DCFS PHNs under DPH. At this time, no objections have been expressed, and this type of consolidated model is the predominate model in other counties statewide.

There is agreement between the departments that it would be beneficial for the DCFS PHN program to be transferred to DPH; and, in concept, the transfer appears to be fiscally viable. However, work continues to ensure the transfer of the DCFS PHN program will not result in a funding shortfall in DPH.

If approved, this consolidation could be accomplished by transferring the DCFS PHN program staff and their associated costs to DPH. In turn, DPH would bill DCFS for the cost of the services provided. DCFS has confirmed they are able to bill the CDSS for

the services received from DPH. DCFS would reimburse DPH and receive offsetting revenue from CDSS utilizing their current, existing Medi-Cal claiming process.

Although other counties have consolidated their PHN staff into one department, they have kept the funding and activities for both the “front-end” and “back-end” PHNs separate. A gradual shift to other funding/staffing models could be done in phases, if necessary, based upon the determination as to the best uses of PHNs in child welfare that would occur as a result of the global discussions the OCP will be leading.

CONCLUSION AND NEXT STEPS

Based on the analysis described above, the OCP believes it is feasible and fiscally viable to transfer the DCFS PHN program over to DPH. There are quite a number of benefits to combining the PHNs under DPH, and the potential detriments identified seem to be concerns that can be resolved.

If the consolidation is approved, DCFS and DPH would need to agree on the specific details as to staffing roles and responsibilities, workload issues, available services and supports, data sharing, training on new processes, and teaming-communication, as well as the fiscal agreement as to billing and other processes and procedures. Once those were agreed upon, a MOU would need to be drafted to memorialize them.

It is, therefore, recommended that this consolidation be considered for approval.

CASELOAD ANALYSIS AND POSSIBLE ASSISTANCE

Table 2: Workload Information

	Measure	Workload ¹
DCFS Front-End	Avg. monthly PHN workload based on # of Children with open ER Referrals and Continuing Services cases assigned to the Regional offices (excluding the #s assigned to the CSW-PHN Joint Initiative)	353
	Avg. # of monthly face-to-face services to children (ER/FM cases) (excluding the #s assigned to the CSW-PHN Joint Initiative)	10
	Measure	Caseload
DPH Back-End	Avg. # of open cases per PHN	302

¹ PHN count used to determine caseload averages excluded vacancies, PHNs on med. leave, Hub PHNs, and CSW-PHN Joint Initiative PHNs

According to the CEO, in working with the two departments to review the caseload data, it became apparent that the data is not collected or recorded in a consistent manner across the two departments. Therefore, the caseload data cannot be compared for the two departments as it is currently collected.

The CEO, DPH, and DCFS will continue to review and analyze the caseload data in order to better understand the time required to complete essential tasks. This will help to inform the work of optimizing the staffing, as these metrics are a key component to developing an efficient and optimum staffing model.

ADDITIONAL INFORMATION

The DCFS report on the Joint Initiative (Attachment II) provides feedback from CSWs and PHNs on the effectiveness of the joint visitation initiative, the overall role of each contributing component, as well as examples of the PHN impact to families as a result of the Pilot program. DCFS' report provides qualitative findings that support positive conclusions about the teamwork of the CSWs and PHNs through this Pilot, as well as identifies the need for further research as to the effect of PHNs on the health of jointly visited children.

Within the next two months, the OCP will organize meetings with DCFS, DPH, the Departments of Health Services, Probation, and Mental Health, advocates, and other key stakeholders to determine the best use of PHNs in child welfare moving forward. A meeting with the PHNs and the union to discuss their vision as to how they could best serve the children and families in their care, keeping safety in mind, has already been scheduled. Once consensus is obtained as to the top recommendations, the OCP will provide the Board with the recommendations generated from those meetings.

In addition, the OCP and DCFS have received a commitment from the Children's Data Network (CDN) to provide further analysis on the CSW-PHN Joint Visitation program. Work is currently being done to allow CDN to match the data from the Joint Visitation program for the evaluation of the program.

If you have any questions, please contact me at (213) 893-1152 or via email at mnash@ocp.lacounty.gov, or your staff may contact Karen Herberts at (213) 893-2466 or via email at kherberts@ocp.lacounty.gov.

MN:CDM:KMH

Attachments (2)

c: Executive Office, Board of Supervisors
 Chief Executive Office
 Children and Family Services
 County Counsel
 Health Services
 Mental Health
 Public Health

Perspectives from Service Employees International Union (SEIU) Local 721 Front-line Child Welfare Nurses and Supervisors on the Proposed Departmental Transfer and Consolidation of Public Health Nurses from DCFS to DPH.

On August 2nd the Los Angeles County Board of Supervisors passed a policy motion authored by Supervisor Hilda Solis and Supervisor Sheila Kuehl (amended by Supervisor Don Knabe) that specifically directed the Los Angeles County Office of Child Protection (OCP) to solicit input from the unions with members affected by the proposed transfer of child-welfare involved public health nurses (PHNs) from the Department of Children and Family Services (DCFS) to the Department of Public Health (DPH). The motion charged the OCP to work in collaboration with both Departments, organized labor, and the County CEO staff to examine the feasibility, benefits, detriments (if any), and fiscal viability of transferring DCFS nurses to DPH into a single consolidated PHN workforce. [The extent to which child-welfare public health nurse roles would be redesigned was not explicitly addressed in the motion.ⁱ]

This document incorporates front-line perspectives from dozens of SEIU Local 721-represented PHNs on the challenges, opportunities, and requirements for a proposed departmental reassignment.

SEIU Child Welfare PHNs

All told, DCFS has approximately 100 Public health nurses (PHNs) –a sub-sample who are specifically assigned to the Blue Ribbon Commission pairing initiative—whereas 75 PHNs work out of the Department of Public Health some of whom also participate in Blue Ribbon Commission work.ⁱⁱ

While highly oversimplified, Los Angeles County’s child-welfare PHNs are classified into two groups. The ‘front-end’ DCFS nurses who typically engage with children and families during crisis, their work is targeted and field-based and the ‘back-end,’ DPH-assigned nurses (Health Care Program for Children in Foster Care-HCPCFP) who do long term care-management of youth in out-of-home placement. Of the approximately 34,500 youth coming into contact with the child welfare system, some 63% are detained by the court in out-of-home placements. Both the DCFS and DPH nursing programs work to best ensure the children achieve optimum health outcomes and are not exposed to secondary neglect (see attached duty statements).

Regardless of their primary duties or programmatic/departmental ‘home’ all SEIU child-welfare PHNs provide critical clinical expertise for fragile and at-risk youth and their families. Both DCFS and DPH based PHNs serve in a consultant capacity and both report to programs that are significantly

underfunded. Child Welfare PHNs do not set bones, give immunizations, or provide direct nursing care—that remains the charge of the children’s medical provider and in some cases teams at the Hubs. Rather they investigate, document, update, validate, and procure medical records—at times engaging in an almost forensic reconstruction of a child’s medical history and prior encounters. Both DCFS and DPH nurses see children of every walk of life and with every possible health condition, including youth with highly-acute and/or chronic conditions. The population includes not only asthmatic and diabetic youth but also youth who are medically-fragile children—youth enrolled in the California Children’s Services program or Regional Center clients—including those with genetic abnormalities, autism, children with gastrostomy tubes or tracheotomies—not to mention an estimated 9 to 11% receiving psychotropic medications.

How and when we engaged with our PHNs: Over the last 36 months SEIU has had numerous opportunities to engage with public health nurses from both DCFS and DPH. For the most part, these ad-hoc convenings were prompted by recent policy discussions but also by specific challenges impacting their work. Including:

- a) The Blue Ribbon Commission for Child Protection (BRCCP) reports, particularly the recommendation that the County consider consolidating the DCFS and DPH PHNs in one administrative department
- b) The subsequent CEO responses to both reports
- c) Subsequent Board of Supervisors actions and policy initiatives stemming from the BRCCP or CEO’s reports-- including the Board of Supervisor’s motion to implement the public health and children’s social worker ‘pairing initiative’ in investigations of suspected or alleged abuse of children under 24 months of age
- d) Separate statewide policy developments including the monitoring of psychotropic medication in child-welfare involved youth, specifically those entering into out-of-home placement (Senate Bill 319)
- e) Other budget advocacy efforts including revenue and budgetary challenges for the Health Care Program for Children in Foster Care (HCPFC) and new mandates (SB 319) and most recently
- f) Convenings requested by the Office of Child Protection or a Board office

In recent weeks and in the last few years (including during the course of SEIU 721 Registered Nurse labor negotiations) SEIU PHNs have consistently and resoundingly articulated a need for a medical/nursing

infrastructure and supportive nursing culture, including a medical/nursing chain of command and clinically-informed training and support that respects their practice and honors their licenses. Today the majority of our PHNs believe the best cultural and professional fit—should the Board decide on one sole department administration of child welfare nursing—would be the Department of Public Health (DPH). Our PHNs support for consolidation is contingent on the following:

Assumptions:

- 1) For lack of any decision to the contrary, the Joint Visit Initiative (also referred to as the ‘PHN--Social Worker Pairing Initiative’ for children under 24 months of age) remains intact and under the administration of DCFS (for the social workers) and DPH for the PHNs.
- 2) Our support also assumes that any decision taken by the Board of Supervisors leading to a transfer/reassignment of programs and personnel would be made with the benefit of *full financial transparency*, including transparency related to existing revenue leveraged and expended by County for nursing activities and in support of nursing activities; revenue from claimable activities, and transparency related to the financing formulas (regardless of receiving department) for *revenue received by* the departments and County and *resources directed toward and/or supporting nursing activities* to child-welfare involved youth (in out-of-home placements or otherwise).
- 3) Assumes that nursing functions would in no way be reduced. And in fact, SEIU seeks assurances from the Board, CEO, and transferring and receiving departments that they will work collaboratively to remedy the chronic state of understaffing impacting the whole CWF nursing enterprise and that County not overestimate potential efficiencies brought about by any consolidation. SEIU nurses want assurances that policy changes will not merely redistribute the workforce but will tackle the staffing and resource challenges head on.
- 4) Recognizes that DCFS and DPH front-line nurses and their supervisors must be brought into to any and all discussions related to Departmental consolidation, and staffing or role redesign.

Presently DPH has a well-honed and established nursing chain of command as well as training and technical support infrastructure that DCFS nurses want. DPH nurses also report that their departmental home and program ‘speaks registered nursing’ and that vulnerable children benefit from a vantage point that grounded in an understanding of the many sociocultural determinants of health.

Opportunities in a Consolidated Child Welfare PHN workforce housed within the Department of Public Health (see attached list of pros/cons and wish list penned by the PHNs in DCFS and DPH)

Specifically PHNs expressed optimism about the opportunity for:

- 1) More consistent communication and protocols under DPH. The current bifurcated system has given rise to silos which are counterproductive to cross-departmental communication and team-building. From the perspective of our public health nurses this departmental bifurcation has allowed for inconsistencies in how PHNs are trained, mentored and coached; how communication is parlayed—including the basics on how data may be tracked or from whom a PHN may request medical records
- 2) Opportunities to benefit from DPH's expertise in training and education—training opportunities that are grounded in appropriate pedagogy and evidenced-based public health practices.
- 3) More opportunities for career advancement and an appropriate nursing/clinical administrative structure. Currently nurses assigned to DPH's HCPCFC have considerably more clinical support and technical assistance—the program includes a supportive nurse manager, medical director, and clinical director which impacts the quality of education and training opportunities. DCFS nurses complain of a lack of training opportunities, and report difficulty navigating and asserting their voice and clinical expertise where the Departmental culture is based on a 'Social Work model' (one that does not resonate with their clinical background and professional practice)
- 4) Clearer administrative protocols and policies that are written from a professional nursing perspective. DCFS PHNs work under policies and protocols that are written from a Social Work perspective.
- 5) Less confusion over roles: Consolidation should assist with role confusion (for example, as to which group of nurses might receive medical records). If nurses were assigned to one department this could mitigate against the confusion from the social workers over the role of the DCFS or DPH PHN, as well as provide more clarity between the respective role of the social worker and PHNs.
- 6) Potential funding stability: If one County department were designated to receive and draw down revenue (potentially, initially through an interdepartmental MOU) and the State were to provide administrative flexibility, and allow a consolidated workforce to engage in claimable activities the programs could be designed more creatively to address the most pressing client need regardless of whether or not a child may have been removed from the home.

In order to become a high-performing child welfare system, LA County will need to swiftly address understaffing. While DCFS nurses recognize the administrative and cultural support and opportunities of a transfer to DPH, many remain anxious about reoccurring budgeting challenges that repeatedly impact the HCPCFC.

Questions and Concerns:

- 1) *How will the County Board of Supervisors support the Department of Public Health in its efforts to leverage funding?* (Funding from the State, highly leveraged federal funding, as well as funding from DCFS and general fund resources etc.)
- 2) *Will funds be sufficient to address the backlogged reports on nurse investigations (DCFS) as well as the consistently high caseloads in HCPCFC?* The Union remains optimistic that the Board and CEO will advocate at the State and Federal levels to provide County resources to support DPH. Additional understanding of the funding streams by the CEO and receiving department and requisite financial transparency from DCFS prior to any transfer is key. The program cannot afford to lose any net resources (such as clerks or others that may currently support PHNs within DCFS) following the proposed transfer.
- 3) *If the OCP, the Board, or either of the Departments recommends not only departmental consolidation but role consolidation or ‘blending’ of nurse consultative functions, how might that blending be accomplished in a workforce that has developed expertise within a specialized part of the child-welfare continuum/system?*

DCFS nurses have been somewhat more vocal in stating their concerns about blending functions—which may result in less field-based work and more highly administrative consultative roles and DPH nurses aren’t assigned to late-night command posts like some of their DCFS counterparts.

- 4) *How will an appropriate staffing model be determined that reflect reasonable ratios of PHN to CSW, and PHN to child?* PHNs in DCFS are assigned anywhere from 14 to 19 units—each composed of six CSWs, all of whom carry a caseload of 30 to 40 youth. One PHN in DCFS has a theoretical caseload of 2,500 cases.ⁱⁱⁱ Although the PHN will not see all of those 2,500, it is impossible to predict the number of children the CSWs will seek them out for a field-visit or a consultation of any kind. The County’s wise commitment to hire more social workers has resulted in CSWs having more time to seek out PHN’s expertise while flat hiring of PHNs means that the same PHN is increasingly stretched among more social workers.

How might PHN-to-child ratios be developed for the on-going care management and health monitoring 'back end' functions regardless of whether or not functions are consolidated? The State HCPCFC MOU indicates a recommended caseload of one PHN to 200 children (prior to the passage of SB 319 which greatly expanded the psychotropic monitoring expectations placed on HCPCFC nurses). Caseloads for DPH-housed foster care nurses average 310 children per PHN with considerable variation by regional office. How will a cash-strapped DPH achieve more reasonable caseloads particularly now with new mandates set on them for psychotropic monitoring?

Recommendations, should the Board decide to consolidate:

- 1) That DCFS and DPH employees, from departmental management to front-line PHN and CSWs must begin a series of trainings that help the two Departments enhance their communication, streamline the work, and build a team approach to child welfare. DCFS and DPH (and by extension the social worker and PHN), have a lot to offer each other through their respective expertise, which will in turn improve the overall safety and care of the children.
- 2) That DCFS and DPH take this opportunity to invest in innovative technology that can help eliminate inefficiencies and improve data collection, assignment of cases, as well as communication.
- 3) That DPH expand the current nurse administrative/clinical and support structure to one that is ready to absorb the 100+ PHNs coming from DCFS and all of the policy, procedure, and training/team building needs that will be required as part of the transition. Nurses have pointed out the need for one nursing director, two nurse managers, a human resources unit, data analysts, a nurse training and education unit, and sufficient amount of clerks (1 per PHN Supervisor) all of whom will be a great asset to the program and would allow the PHN to focus the majority of their time on the medical needs of the children. The nurses strongly expressed a need for a nursing director specific to the Child Welfare program given the medical complexity of the population and oft-changing demands/mandates handed down from the State. The nurses also need a strong clinical nursing structure that can advocate for the value that they add to the health and wellbeing of the children and the families in this population. Some level of inefficiencies will continue to persist, even with consolidation, precisely due to the reality that the roles of the social worker and public health nurses—two critical parties necessary for the safety, health and wellbeing of these youth—are not always aligned. Public health nurses are

charged with assessing threats to the health and wellbeing of a child, which can lead to secondary prevention of abuse or neglect. Making a health assessment of the children can take time, especially if medical records need to be requested, reviewed and validated. A social worker is charged with determining the safety risks for a child and consulting on a health issue that may indicate a safety risk. Consulting a PHN can cause delays and can result in social workers not closing their investigations during expected timelines. Similarly social workers may be frustrated if they must compete with other social workers for fewer nurse consultants to schedule an in-home or in-facility visit. These very real operational concerns need to be hashed out once the transfer occurs and in collaboration with their social work and management counterpart.

Conclusion:

Overall the nurses see the potential transition and consolidation to DPH to be an exciting opportunity to build a rock solid Child Welfare nursing program. Although the nurses have some concerns and cautions about combining the programs, we believe that through continued dialogue and participation in a robust and inclusive process with the Office of Child Protection and DCFS and DPH administration, that those concerns can be sufficiently resolved.

ⁱ SEIU requests that the County engage in a thoughtful study including nurses, social workers, nurse managers, and others to better understand the varied roles that PHNs play with this vulnerable population before briskly deciding on restructuring.

ⁱⁱ As of January 2016, HCPCFC has been under a hiring freeze and is currently working with 67 PHNs

ⁱⁱⁱ Based on one PHN providing consultative services to 84 CSWs each carrying a caseload of 30 youth.

PROS/CONS

Pros	Cons
<ol style="list-style-type: none"> 1. Continuity of care for a child 2. Increase autonomy to make decisions on behalf of a child 3. Under one reporting structure – Medical/Nursing model. 4. Uniformity of practice and nursing documentation. 5. Fully function under the Department of Public Health's mission - "To protect health, prevent disease, and promote health and well-being." 6. Uniformity of work for the child and family. 7. Increase resources available 8. Decrease in confusion regarding PHN coverage 9. All PHNs will have equal opportunities for training and education hours. 10. Stronger children's advocacy 11. As one program, to share the same body of knowledge. 	<ol style="list-style-type: none"> 1. It will not solve PHN and ITC shortage for both DCFS and DPH nursing program that affects delivery of service to the children and families. 2. Possible increase in workload due to the perception that there is an increase in nursing staff 3. Department of Public Health (DPH) – Children's Medical Services (CMS) shares Human Resource Support staff, Computer Support, and Nursing Director with Child Health and Disability (CHDP) and California Children's Services (CCS) program. DPH/CMS cannot handle the increase in incoming DCFS staff with the consolidation of the program. There is already an increase of waiting time for Mileage requests, changing of computer passwords, pattern i.d. changes for jury duty, etc. which decreases time spent on children and families 4. Potential of continued inefficiencies if PHN staffing is not improved and/or the differences in roles between the PHN (medical concerns) and Social Workers (safety concerns) are not better aligned 5. Change of supervision and management 6. Different skills and requirements from DCFS and DPH workforce - nursing administration, PHN, & ITC. Difference in training and hiring process

Wish List

1. Flexible schedule to allow for office coverage and CSW access to nursing staff (such as 4/40 schedule)
2. Own education, human resource, tech support unit, administration to handle the large employee workforce; we would like adequate support to assist the staff with providing continuity of care to our clients
3. Resource website that is current to provide accurate information to our clients
4. Education to do training of staff, CSW and caregivers for PHNs to focus of specific child health care needs
5. HUB unit in the East Valley area (Pomona, Glendora area) – creates access for those clients who live in the East area
6. Court Pediatrician housed at the court. Need access to assist with medical, developmental health care needs of the children and assist with court orders.
7. Uniformity in forms to assist with access to medical records, communication on behalf of our clients
8. Increase access to HUB nursing staff in coordination of care and obtaining medical records for our clients
9. Training Unit to provide same consistent training of all staff – stronger workforce for our clients
10. Job security in terms of adequate amount of money for the budget – avoid layoffs and cost cutting measures that can affect our clients
11. Maintain a fair and equitable assignment to ensure all client's needs are being met
12. ITC clerical support, to be classified as STC if possible
13. All Child Welfare Nursing Staff to obtain access the DHS Orchid medical record system.

CSW/PHN JOINT VISIT INITIATIVE

Literature supports the merits of multi-disciplinary teaming as an efficient strategy by which to approach the complex issues that confront the Department of Children and Family Services (DCFS) on a daily basis in fulfilling its mandate to protect children. With the goal of supporting the best casework decisions for the child and the family, existing departmental policy already required Children's Social Workers (CSW) to consult with co-located Public Health Nurses (PHNs) when a known or suspected medical or developmental challenge existed.

This Departmental Policy was expanded as a result of the recommendation by the Blue Ribbon Commission on Child Protection to develop a CSW/PHN Joint Visit Initiative, with the purpose of enriching specialized expertise during the course of conducting investigations of alleged abuse and neglect of the County's most vulnerable very young children ages, 0-12 months, regardless of their medical status.

On August 3, 2015, in partnership with the Department of Health Services' (DHS) Martin Luther King, Jr. Outpatient Center, DCFS launched Phase One of the CSW/PHN Joint Visit Initiative in the Compton and Vermont Corridor Regional Offices and at the Emergency Response Command Post.

During the August 2, 2016 meeting of the Los Angeles County Board of Supervisors, County Supervisor Mark Ridley-Thomas instructed DCFS Director Philip L. Browning to ***"...report back with further research and analysis, including soliciting feedback from Children's Social Workers and Public Health Nurses, on the effectiveness of the Joint Visitation Initiative, the pilot effort and the overall role of each contributing component; and to consider soliciting feedback for the families that have been or would be served by the Pilot program."***

The following comprises DCFS' response:

Throughout Phase One of the CSW/PHN Joint Visit Initiative, participating PHNs and CSWs equally reported that, with exception of a few, most families were generally friendly and cooperative once the jointly visiting PHN explained their purpose. By skillfully associating their presence as a means of assuring access to necessary health needs and/or services for the children and family, PHNs answered questions related to medication; advised parents on developmental milestones/delays; and provided educational materials on service linkages for obesity prevention; co-sleeping education; dental, immunizations, well-child exams; and early childhood education.

The joint visiting PHN's good-natured approach resulted in deeper engagement, enabling the PHN to apply medical training, experience and standardized assessment to form observational "hunches" and gather enough information to recommend necessary service linkages for the child and for the family. For the most part, PHNs engaged with thousands of fairly healthy children, most of who were found to be behind in vaccinations or physical/dental examinations. However, other children had gone without prescribed medication and/or their parents had not followed up with recommended specialty medical services. While the vast majority of PHN-identified "unmet needs" did not support the opening of a child welfare case, they did result in referrals to necessary

early intervention services or in educating parents on healthy preventive practices that would benefit their children's futures. The joint visits may have resulted in fewer cases being opened or children removed from their homes when compared to the same timeline prior to this initiative. Further analysis in this area is needed.

**FEEDBACK FROM CHILDREN'S SOCIAL WORKERS AND PUBLIC HEALTH NURSES:
THE EFFECTIVENESS OF THE INITIATIVE; AND
THE OVERALL ROLE OF EACH CONTRIBUTING COMPONENT**

Despite the few families who were resistant to the joint-visit, CSWs generally observed that families responded favorably to the PHN's presence because they had an opportunity to ask medically-specific questions and also had an opportunity to be educated on how to become a better advocate with medical providers on their children's behalf.

Through implementation of the CSW/PHN Joint Visit Initiative – Phase One, PHNs readily accepted the core values of the child welfare system and also included "health" as part of "safety." Despite the ongoing barriers of competing mandates/goals; resource limitations, and different managers, jointly visiting PHNs became advocates for the child, the family and for the system itself.

Second Set of Eyes

CSWs have historically requested that there be a "buddy system" when responding to Child Protection Hotline referrals. CSWs found value and felt reassured in having the second "set of eyes" while assessing children. The joint visit allowed the opportunity for the visiting PHN and the investigating CSW to debrief on their observations. In particular, CSWs felt more comfortable with having a PHN on-hand to assess non-verbal children for possible symptoms of medical neglect.

Service Linkages

PHNs were able to identify conditions that, if not addressed immediately, would have potentially led to future physical, psychological, cognitive and social challenges. Based upon observed and identified "unmet needs," PHNs made recommendations for appropriate medical evaluations, nutritional services, behavioral counseling, government assistance, and educational needs based upon observations in the home or upon further review of medical records. Aside from early intervention services, PHNs also provided service linkage recommendations to Head Start programs, dental providers, and specialty medical providers.

Operational Challenges

As with any new program, implementation of the CSW/PHN Joint Visit Initiative – Phase One - also provided the learning opportunities to improve operations. It wasn't always possible for the CSW and the PHN to initially visit the home at the same time.

1. Disparate CSW-PHN Ratio

There are more CSWs than there are PHNs. The staffing disparity impacted DCFS' ability to manage immediate joint responses. In many instances, CSWs often needed to revisit a home they would not have otherwise revisited only because the PHN was not available at the time of the initial visit, and the PHN is not authorized to visit the home without the investigating CSW. ***CSWs would prefer that PHNs be authorized to visit a home without them.***

2. CSW and PHN Schedule Coordination

In many instances, the operational challenge of coordinating the alternative work schedules of CSWs and PHNs while balancing compliance with referral response times resulted in a CSW conducting an initial home visit without a PHN and then having to return to the same home with the PHN – a practice that imposed upon the CSW’s time to complete other tasks or investigations. This impact was further amplified in those instances where a third or fourth visit was needed because all of the children were not at home during the second visit. In other instances, the paired PHN was only able to jointly visit towards the end of an investigation, finding it difficult to manage completing their health-related tasks prior to the closure of an investigation. ***PHNs would prefer to have more time to complete their tasks, not associated with a CSW’s regulatory referral closure time.***

3. Documentation

The length of time for PHN documentation in CWS/CMS occasionally delayed the closure of ER referrals. Some CSWs noted inconsistencies in the quality of PHN documentation, from some that are very detailed to others that are very brief. ***CSWs would prefer a change in current procedure that, based upon the CSW/PHN consultation, requires the CSW to initiate requests for medical records and to forward service linkage referrals to families.***

4. Language Barriers

There is a need from more Spanish-speaking PHNs to better serve families residing within the catchment areas of the Compton and Vermont Corridor offices. ***PHNs would prefer additional hiring, not only to improve pairing success on the initial visit, but also specialized hiring to address language barriers.***

FEEDBACK FROM FAMILIES

In a few instances, jointly visited families claimed to know more about their children than they actually demonstrated. When the visiting PHN asked families to explain/demonstrate their knowledge about their children, it produced child well-being teaching opportunities. For example, PHNs taught families how to store food and to protect/advocate for their children in many varied situations. PHNs also helped make referrals for mental health evaluations linked to possible post-partum depression or anger management, veiled conditions that often go undetected.

Jointly-visited families were more relaxed in the presence of the PHN. On occasion, children provided more information than their caregivers. The following examples illustrate a PHN’s impact during a joint visit.

Example 1 – Parent Education

A PHN accompanied an investigating CSW on a joint visit of a young, first-time mother. During the visit, the PHN asked the mother to prepare a bottle of formula for her newborn only to observe that the mother was not mixing the formula correctly. The PHN proceeded to educate the young mother. Generally, a CSW would not have thought of asking a first-time mother to demonstrate how mix formula. Henceforth, this CSW will be doing so in similar circumstances as part of everyday practice.

Example 2 – Diffusing Tense Situation with Parent

A PHN arrived at the Hawthorne Police Department Jail facility as the investigating CSW was departing with a 14-month-old child. Earlier that day, the police had taken the child and her mother into police custody. The mother was crying inconsolably to the point of exhaustion; and the CSW, in the process of removing the child from her mother's custody, informed the PHN that the mother was "uncooperative" and unwilling to provide the CSW with information on the child's health.

Upon receiving consent, the PHN's calm and nurturing demeanor successfully refocused mother back onto her child's needs. The mother provided the PHN with the name of the family pediatrician; information on the child's diet and birth history; the mother cooperated with the PHN in responding to checklist questions on the child's known allergies or suspected medical or developmental concerns.

Example 3 – Linkage to Medical Hub Services

A PHN accompanied an investigating CSW on a second visit to the home of a two-month old infant, where the infant resided with her mother and three siblings under the age of five. The family was under an open Family Maintenance case. When the PHN inquired about any medical concerns, the infant's mother reported that the baby had been making "noise and gasping for air at times," however, during a recent physical exam, the infant's primary care physician stated that the symptom was not concerning. Upon the PHN's further probe, the mother denied skin color changes during the episodes.

The PHN advised mother to continue monitoring the infant's breathing patterns and to call 911 if symptoms changed; the PHN then proceeded to initiate a Hub referral for an additional medical screen. The mother consented to the medical screen and transported the infant to the Hub appointment scheduled for the following day. During the MLK Hub appointment, Dr. Janet Arnold-Clark diagnosed the infant with congenital laryngomalacia

Laryngomalacia results in partial airway obstruction, most commonly causing a characteristic high-pitched squeaking noise on inhalation. It becomes symptomatic after the first 2-3 months of life; and the squeaking noise may get louder over the first year, as the child moves air more vigorously. Some infants have feeding difficulties related to this problem. While the vast majority will not, on rare occasion, children will have significant life threatening airway obstruction. Most cases resolve spontaneously and less than 15% of the cases will need surgical intervention. Parents need to be supported and educated on the condition.

CONCLUSION

While the above-noted initial qualitative findings clearly support positive conclusions about the teamwork of CSWs and PHNs through the Joint Visit Initiative, future research is suggested in several areas, including the effect of PHNs on the health of jointly visited children. Longitudinal studies should focus on whether PHNs are able to meet the health care needs of this fragile population and whether that care affects children's long-term health outcomes. Research into how CSWs and PHNs shape intervention choices will make health case management of foster children more successful.